Generations
GERIATRIC MENTAL HEALTH
PO Box 3300, Manchester, NH 03105
(603) 645-5977 Fax (603) 645-5980

Date Request Received: _____

Date Sent/Initials: _____/____
Sent via: ☐Fax ☐Mail ☐Pick-up

MEDICAL RECORDS REQUEST FORM

Patient Name: _____ **Date of Birth**: _____
Address:_____
City: _____ State: _____ Zip: _____ Phone: _____

Receiving Party: (Where do you want information sent?)
Name: _____
Address:_____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Records Requested: _____
_____

Date(s) of Service: From _____ to _____

Requested By:
☐ Self/Patient ☐ *Activated* HC-DPOA _____ ☐ Guardian _____
☐ Medicare ☐ Insurance: _____ ☐ Provider: _____
☐ Other: _____

Patient/Legal Agent Signature: _____ Date: _____

IMPORTANT: A RELEASE OF AUTHORIZATION FORM MUST ACCOMPANY THIS REQUEST FORM WHEN RECORDS WILL BE RELEASED TO ANYONE OTHER THAN THE PATIENT OR HIS/HER ACTIVATED DPOA OR GUARDIAN.

Reason for Request:
☐ Personal ☐ __Continuation/__ Transfer of Care
☐ Insurance Audit ☐ LTC Insurance ☐ __Nsg Home/__ALF Admission
☐ Disability Claim ☐ Research Study ☐ Guardianship
☐ Other: _____

Name of Office Staff Requesting: _____

Approval Signatures:

Provider Name	Provider Signature	Date
Provider Name	Provider Signature	Date
Provider Name	Provider Signature	Date

Comments: _____